FOR OHF USE

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2005
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2005)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0016964

Facility Name: BOHANNON NURSING HOME

Address: 1201 NORTH ALTON (Number) LEBANON (City) 62254 (Zip Code)

County: ST. CLAIR

Telephone Number: (618) 537-4401 **Fax #** (618) 537-4447

IDPA ID Number: 37-0708824-001

Date of Initial License for Current Owners: 04/06/1950

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
		X	"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: WILLIAM J. PURK, CPA **Telephone Number:** (314) 862-2070

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/2005 to 12/31/2005 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) _____ (Date)
(Type or Print Name) KENNETH BOHANNON
(Title) PRESIDENT

Paid Preparer

(Signed) _____ (Date)
(Print Name and Title) WILLIAM J. PURK, CPA, PRESIDENT
(Firm Name & Address) MPP&W, P.C., 1034 S. BRENTWOOD, STE. 1700 ST. LOUIS, MO 63117
(Telephone) (314) 862-2070 Fax # (314) 862-1549

MAIL TO: BUREAU OF HEALTH FINANCE
ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

Facility Name & ID Number BOHANNON NURSING HOME # 0016964 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	101	Skilled (SNF)	101	36,865	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	101	TOTALS	101	36,865	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	13,172	6,573	503	20,248	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	13,172	6,573	503	20,248	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 54.92%

D. How many bed-hold days during this year were paid by the Department?
NONE (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
NONE

F. Does the facility maintain a daily midnight census? YES

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [X] NO [ ]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [X] NO [ ]

I. On what date did you start providing long term care at this location?
Date started 04/12/1972

J. Was the facility purchased or leased after January 1, 1978?
YES [ ] Date _____ NO [X]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 9 and days of care provided 503

Medicare Intermediary ADMINASTAR FEDERAL

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/2005 Fiscal Year: 12/31/2005

* All facilities other than governmental must report on the accrual basis.

STATE OF ILLINOIS

Facility Name & ID Number BOHANNON NURSING HOME # 0016964 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	133,611	4,473	4,645	142,729		142,729		142,729			1
2	Food Purchase		81,469		81,469		81,469	(1,128)	80,341			2
3	Housekeeping	72,815	6,252		79,067		79,067		79,067			3
4	Laundry	25,959	3,575	2,213	31,747		31,747		31,747			4
5	Heat and Other Utilities			64,033	64,033		64,033		64,033			5
6	Maintenance	19,145	4,153	16,318	39,616		39,616		39,616			6
7	Other (specify):*											7
8	**TOTAL General Services**	251,530	99,922	87,209	438,661		438,661	(1,128)	437,533			8
	B. Health Care and Programs											
9	Medical Director			6,300	6,300		6,300		6,300			9
10	Nursing and Medical Records	797,552	41,027	28,424	867,003		867,003	(2,882)	864,121			10
10a	Therapy	17,978	14,017	325,624	357,619		357,619	(357,619)				10a
11	Activities	27,013	4,087	1,626	32,726		32,726		32,726			11
12	Social Services	25,740		1,278	27,018		27,018		27,018			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	868,283	59,131	363,252	1,290,666		1,290,666	(360,501)	930,165			16
	C. General Administration											
17	Administrative	51,231		18,710	69,941		69,941	(9,375)	60,566			17
18	Directors Fees											18
19	Professional Services			31,594	31,594		31,594	(2,875)	28,719			19
20	Dues, Fees, Subscriptions & Promotions			8,114	8,114		8,114	(5,511)	2,603			20
21	Clerical & General Office Expenses	45,832	4,490		50,322		50,322		50,322			21
22	Employee Benefits & Payroll Taxes			159,433	159,433		159,433	(49)	159,384			22
23	Inservice Training & Education											23
24	Travel and Seminar			807	807		807		807			24
25	Other Admin. Staff Transportation			63	63		63		63			25
26	Insurance-Prop.Liab.Malpractice			47,339	47,339		47,339		47,339			26
27	Other (specify):*											27
28	**TOTAL General Administration**	97,063	4,490	266,060	367,613		367,613	(17,810)	349,803			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	1,216,876	163,543	716,521	2,096,940		2,096,940	(379,439)	1,717,501			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number BOHANNON NURSING HOME #0016964 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			47,456	47,456		47,456	1,833	49,289			30
31	Amortization of Pre-Op. & Org.			1,487	1,487		1,487		1,487			31
32	Interest			6,961	6,961		6,961	(6,961)				32
33	Real Estate Taxes			24,595	24,595		24,595		24,595			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			8,908	8,908		8,908		8,908			35
36	Other (specify):*											36
37	**TOTAL Ownership**			89,407	89,407		89,407	(5,128)	84,279			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers			6,883	6,883		6,883	(6,176)	707			39
40	Barber and Beauty Shops		4,191		4,191		4,191	(3,714)	477			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			50,653	50,653		50,653		50,653			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**		4,191	57,536	61,727		61,727	(9,890)	51,837			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	1,216,876	167,734	863,464	2,248,074		2,248,074	(394,457)	1,853,617			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number BOHANNON NURSING HOME # 0016964 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(1,128)	2		4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	1,833	30		9
10	Interest and Other Investment Income	(6,961)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions	(130)	17		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(5,511)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(382,560)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (394,457)		$	30

OHF USE ONLY								
48		49		50		51		52

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)			34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (394,457)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

STATE OF ILLINOIS

BOHANNON NURSING HOME

ID# 0016964

Report Period Beginning: 01/01/2005

Ending: 12/31/2005

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Barber & Beauty Shop Revenue	$ (3,714)	40	1
2	Employee Gifts	(49)	22	2
3	Legal Fees	(2,875)	19	3
4	Therapy Revenue	(357,619)	10A	4
5	Patient Medical Supply Revenue	(2,882)	10	5
6	Pharmacy	(6,176)	39	6
7	Miscellaneous Income	(9,245)	17	7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(382,560)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number BOHANNON NURSING HOME # 0016964 **Report Period Beginning:** 01/01/2005 **Ending:** 12/31/2005

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(1,128)	0	0	0	0	0	0	0	0	0	0	(1,128)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(1,128)	0	0	0	0	0	0	0	0	0	0	(1,128)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	(2,882)	0	0	0	0	0	0	0	0	0	0	(2,882)	10
10a	Therapy	(357,619)	0	0	0	0	0	0	0	0	0	0	(357,619)	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	(360,501)	0	0	0	0	0	0	0	0	0	0	(360,501)	16
	C. General Administration													
17	Administrative	(9,375)	0	0	0	0	0	0	0	0	0	0	(9,375)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(2,875)	0	0	0	0	0	0	0	0	0	0	(2,875)	19
20	Fees, Subscriptions & Promotions	(5,511)	0	0	0	0	0	0	0	0	0	0	(5,511)	20
21	Clerical & General Office Expenses	0	0	0	0	0	0	0	0	0	0	0	0	21
22	Employee Benefits & Payroll Taxes	(49)	0	0	0	0	0	0	0	0	0	0	(49)	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	(17,810)	0	0	0	0	0	0	0	0	0	0	(17,810)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(379,439)	0	0	0	0	0	0	0	0	0	0	(379,439)	29

STATE OF ILLINOIS **Summary B**

Facility Name & ID Number BOHANNON NURSING HOME **#** 0016964 **Report Period Beginning:** 01/01/2005 **Ending:** 12/31/2005

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS (to Sch V, col.7)	
30	Depreciation	1,833	0	0	0	0	0	0	0	0	0	0	1,833	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(6,961)	0	0	0	0	0	0	0	0	0	0	(6,961)	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(5,128)	0	0	0	0	0	0	0	0	0	0	(5,128)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	(6,176)	0	0	0	0	0	0	0	0	0	0	(6,176)	39
40	Barber and Beauty Shops	(3,714)	0	0	0	0	0	0	0	0	0	0	(3,714)	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	(9,890)	0	0	0	0	0	0	0	0	0	0	(9,890)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(394,457)	0	0	0	0	0	0	0	0	0	0	(394,457)	45

Facility Name & ID Number BOHANNON NURSING HOME # 0016964 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
KEN BOHANNON	100	NONE				

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [ ] YES [X] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1 Schedule V	2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V			$			$	$	1
2	V								2
3	V								3
4	V								4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$			$	$ *	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number BOHANNON NURSING HOME # 0016964 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	KEN BOHANNON	PRESIDENT	Asst. Administrato	100.00	0	24	60.00	SALARY	$ 6,200	Ln 17, Col 1	1
2	LEE BOHANNON-SMITH	NONE	Administrator	0.00	0	40	100.00	SALARY	45,031	Ln 17, Col 1	2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 51,231		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION.

Facility Name & ID Number BOHANNON NURSING HOME # 0016964 Report Period Beginning: 01/01/2005 Ending: 2/31/2005

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [ ] NO [X]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1		NOT APPLICABLE				$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number BOHANNON NURSING HOME # 0016964 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	SMALL BUS. ADMIN.		X	Addition Construction	$2,813.00	11/12/86	$ 332,000	$ 27,977	11/12/06	0.0800	$ 3,444	1
2	BANK OF O'FALLON		X	Refinance (Construction)	$562.00	03/31/03	75,420	69,308	02/28/06	0.0650	3,204	2
3	BANK OF O'FALLON-LOC		X	Line of Credit	Various	04/14/05		44,735	04/14/10	0.0825	313	3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related				$3,375.00		$ 407,420	$ 142,020			$ 6,961	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 407,420	$ 142,020			$ 6,961	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. **$** _____ **Line #** _____

*** Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)**

**** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)**

Facility Name & ID Number BOHANNON NURSING HOME # 0016964 **Report Period Beginning:** 01/01/2005 **Ending:** 12/31/2005

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.

1. Real Estate Tax accrual used on 2004 report.	$	40,271	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$	42,577	2
3. Under or (over) accrual (line 2 minus line 1).	$	2,306	3
4. Real Estate Tax accrual used for 2005 report. (Detail and explain your calculation of this accrual on the lines below.)	$	22,289	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**	$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**	$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$	24,595	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2000	37,564	8
	2001	38,132	9
	2002	38,314	10
	2003	40,271	11
	2004	42,577	12

LINE 2 - PAYMENT APPLIES TO CALENDAR YEAR 2004

LINE 4 - ACCRUAL FOR 2005 IS BASED ON THE EXPECTED BILL AMOUNT FOR 2006.

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2004	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2004 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2004 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2004.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2004 real estate tax bill to the Department of Public Aid, Bureau of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2005 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Bureau of Health Finance at (217) 782-1630.

2004 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME BOHANNON NURSING HOME COUNTY ST. CLAIR

FACILITY IDPH LICENSE NUMBER 0016964

CONTACT PERSON REGARDING THIS REPORT LEE BOHANNON-SMITH

TELEPHONE (618) 537-4401 FAX #: (618) 537-4447

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2004 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2004.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	05-18.0-300-019	FACILITY	$ 41,831.00	$ 41,831.00
2.	05-18.0-300-018	FACILITY	$ 746.00	$ 746.00
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 42,577.00	$ 42,577.00

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? _____ YES X NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the original 2004 tax bills which were listed in Section A to this statement. Be sure to use the 2004 tax bill which is normally paid during 2005.

Facility Name & ID Number BOHANNON NURSING HOME # 0016964 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 31,919 B. General Construction Type: Exterior Brick Frame Concrete & Steel Number of Stories 1

C. Does the Operating Entity? [X] (a) Own the Facility [ ] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [ ] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

N/A

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization: 4. Dates Incurred:

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	NURSING HOME	174,240	1972	$ 10,000	1
2					2
3	TOTALS	174,240		$ 10,000	3

Facility Name & ID Number BOHANNON NURSING HOME # 0016964 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	51		1972	1972	$ 514,667	$ 12,867	40	$ 12,867	$	$ 433,178	4
5	50		1986	1986	691,511	19,666	40	17,288	(2,378)	335,671	5
6											6
7											7
8											8
	Improvement Type**										
9	BUILDING EQUIPMENT			1972	67,551		10			67,551	9
10	HEATING SYSTEM, AIR CONDITIONER			1978	18,296		15			18,296	10
11	FIRE ALARM			1980	3,770		25			3,770	11
12	FAN SYSTEM			1982	1,388		20			1,388	12
13	ROOF			1983	38,993		25	1,560	1,560	35,614	13
14	SHED & ALARM			1983	7,672		20			7,672	14
15	GAS LINE			1984	694		30	23	23	507	15
16	HEAT PUMPS			1984	11,560		15			11,560	16
17	CHART SYSTEM, WINDOWS, DOORS			1984	3,847		20			3,847	17
18	AIR CONDITIONERS			1985	1,524		8			1,524	18
19	WATER HEATERS			1985	3,106		15			3,106	19
20	SPRINKLER SYSTEM			1986	39,807	1,135	25	1,592	457	30,917	20
21	STORAGE TRAILER			1986	1,806		20			1,806	21
22	WATER HEATER, NURSE CALL			1986	2,026		15			2,026	22
23	ALARM, FIRE EXTINGUISHER, PHONES			1986	859		10			859	23
24	WATER HEATER			1990	2,185		15			2,185	24
25	WATER HEATER			1991	2,034		15	136	136	1,910	25
26	PHONE, HEATER UNIT			1992	1,799		10			1,799	26
27	AIR CONDITIONER			1993	7,689		10			7,689	27
28	AIR CONDITIONER			1995	2,385		10			2,385	28
29	WATER SOFTENER			1996	500	30	12	42	12	406	29
30	FRONT CIRCLE DRIVE			1998	8,715	507	15	581	74	4,455	30
31	PARKING LOT, FUEL TANK			1998	21,522	1,301	20	1,428	127	10,130	31
32	WATER SOFTENER			1998	2,764		12	230	230	1,689	32
33	HEATING/COOLING UNIT			1999	8,685	783	10	869	86	5,356	33
34	ROOF			2000	15,823	986	20	791	(195)	4,285	34
35	WATER HEATERS			2000	5,810	519	15	387	(132)	2,227	35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number BOHANNON NURSING HOME # 0016964 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	PORTABLE ASPIRATOR, PHONE SYSTEM	2001	$ 3,925	$	10	$ 393	$ 393	$ 1,832	37
38	WINDOWS	2001	7,905	569	40	198	(371)	823	38
39	TRASH COMPACTOR	2002	8,462		10	847	847	3,314	39
40	LIFT TRUCK	2002	782	68	10	78	10	300	40
41	DOOR ALARM	2002	2,242		10	224	224	747	41
42	AIR CONDITIONER	2003	5,150	440	20	258	(182)	708	42
43	WATER HEATER	2004	3,203	784	15	214	(570)	391	43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 1,520,657	$ 39,655		$ 40,006	$ 351	$ 1,011,923	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number BOHANNON NURSING HOME # 0016964 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 83,045	$ 7,801	$ 9,283	$ 1,482		$	71
72	Current Year Purchases							72
73	Fully Depreciated Assets	263,589						73
74								74
75	TOTALS	$ 346,634	$ 7,801	$ 9,283	$ 1,482		$	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				$	$	$	$		$	76
77										77
78										78
79										79
80	TOTALS			$	$	$	$		$	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount		
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 1,877,291	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 47,456	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 49,289	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 1,833	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 1,011,923	85	

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86	25% Plane & Radio 1982	$ 6,574	$	$ 6,574	86
87	25% Plan Engine 1988	3,394		3,394	87
88	25% Storm Scope 1986	2,347		2,347	88
89	Pickup Truck 1979	8,743		8,072	89
90					90
91	TOTALS	$ 21,058	$	$ 20,387	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number BOHANNON NURSING HOME # 0016964 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4? If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34. This amount was calculated by dividing the total amount to be amortized by the length of the lease .

9. Option to Buy: ☐ YES ☐ NO Terms: *

10. Effective dates of current rental agreement:
Beginning
Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2006	$
13.	/2007	$
14.	/2008	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO
16. Rental Amount for movable equipment: $ 5,151 Description: Copier ($4,780) + Computer ($321) + Hydrant ($50)
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number BOHANNON NURSING HOME # 0016964 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

XIII. EXPENSES RELATING TO CERTIFIED NURSE AIDE (CNA) TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If CNAs are trained in another facility program, attach a schedule listing the facility name, address and cost per CNA trained in that facility.)

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?
   - [ ] YES
   - [X] NO

   If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER CNA ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER CNA ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training CNAs from other facilities.

$

D. NUMBER OF CNAs TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.
(e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

Facility Name & ID Number BOHANNON NURSING HOME # 0016964 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	Line 10a, Col 3	hrs	$	1,895	$ 114,204	$	1,895	$ 114,204	1
2	Licensed Speech and Language Development Therapist	Line 10a, Col 3	hrs		1,453	94,045		1,453	94,045	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	Line 10a, Col 3	hrs		1,930	117,375		1,930	117,375	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	Line 10, Col 2	# of prescrpts				6,883		6,883	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify): X-Ray	Line 10, Col 3		828					828	13
14	TOTAL			$ 828	5,278	$ 325,624	$ 6,883	5,278	$ 333,335	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as CNAs, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number BOHANNON NURSING HOME **#** 0016964 **Report Period Beginning:** 01/01/2005 **Ending:** 12/31/2005

XV. BALANCE SHEET - Unrestricted Operating Fund. **As of** 12/31/2005 **(last day of reporting year)**

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 61,367	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	214,205		3
4	Supply Inventory (priced at)	9,881		4
5	Short-Term Investments			5
6	Prepaid Insurance	17,363		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 302,816	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments	145,995		12
13	Land	10,000		13
14	Buildings, at Historical Cost	1,520,657		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	367,692		16
17	Accumulated Depreciation (book methods)	(1,747,149)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):	10,100		22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 307,295	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 610,111	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 8,582	$	26
27	Officer's Accounts Payable	428,740		27
28	Accounts Payable-Patient Deposits	3,764		28
29	Short-Term Notes Payable	44,735		29
30	Accrued Salaries Payable	25,101		30
31	Accrued Taxes Payable (excluding real estate taxes)	12,011		31
32	Accrued Real Estate Taxes(Sch.IX-B)	22,289		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Accrued Profit Sharing Contr.	677		36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 545,899	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	97,285		39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 97,285	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 643,184	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (33,073)	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 610,111	$	48

***(See instructions.)**

Facility Name & ID Number BOHANNON NURSING HOME # 0016964 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 324,494	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 324,494	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(443,995)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe) PRIOR PERIOD ADJUSTMENT	86,428	15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (357,567)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ (33,073)	24 *

*** This must agree with page 17, line 47.**

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XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 1,614,870	1
2	Discounts and Allowances for all Levels	(347,186)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 1,267,684	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	492,160	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 492,160	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	3,714	13
14	Non-Patient Meals	1,128	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	6,176	17
18	Sale of Supplies to Non-Patients	2,882	18
19	Laboratory	703	19
20	Radiology and X-Ray	99	20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 14,702	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	20,238	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 20,238	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	TRANSPORTATION INCOME	50	28
28a	MISCELLANEOUS INCOME	9,245	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 9,295	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 1,804,079	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	438,661	31
32	Health Care	1,290,666	32
33	General Administration	367,613	33
	B. Capital Expense		
34	Ownership	89,407	34
	C. Ancillary Expense		
35	Special Cost Centers	61,727	35
36	Provider Participation Fee		36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 2,248,074	40
41	**Income before Income Taxes (line 30 minus line 40)****	(443,995)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (443,995)	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? NO If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

**** **Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

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XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,968	2,080	$ 53,976	$ 25.95	1
2	Assistant Director of Nursing					2
3	Registered Nurses	4,032	4,328	99,193	22.92	3
4	Licensed Practical Nurses	12,931	13,289	232,930	17.53	4
5	CNAs & Orderlies	37,834	39,890	397,524	9.97	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	1,396	1,530	17,978	11.75	8
9	Activity Director	1,936	2,072	22,464	10.84	9
10	Activity Assistants	701	701	4,549	6.49	10
11	Social Service Workers	1,976	2,080	25,740	12.38	11
12	Dietician					12
13	Food Service Supervisor	1,952	2,080	26,728	12.85	13
14	Head Cook	4,373	4,601	38,620	8.39	14
15	Cook Helpers/Assistants	8,859	9,260	68,263	7.37	15
16	Dishwashers					16
17	Maintenance Workers	1,452	1,476	19,145	12.97	17
18	Housekeepers	8,601	8,941	72,815	8.14	18
19	Laundry	3,452	3,544	25,959	7.32	19
20	Administrator	1,896	2,080	45,031	21.65	20
21	Assistant Administrator	1,040	1,040	6,200	5.96	21
22	Other Administrative					22
23	Office Manager	1,772	1,936	24,926	12.88	23
24	Clerical	1,868	1,936	20,906	10.80	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,595	1,659	13,929	8.40	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	99,634	104,523	$ 1,216,876 *	$ 11.64	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	105	$ 5,142	Ln 1, Col 3	35
36	Medical Director	48	6,300	Ln 9, Col 3	36
37	Medical Records Consultant	16	620	Ln 10, Col 3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	48	1,010	Ln 10, Col 3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	24	1,278	Ln 11, Col 3	44
45	Social Service Consultant	24	1,626	Ln 12, Col 3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	265	$ 15,976		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	15	$ 443	Ln 10, Col 3	50
51	Licensed Practical Nurses	523	15,621	Ln 10, Col 3	51
52	Certified Nurse Assistants/Aides	357	6,354	Ln 10, Col 3	52
53	TOTAL (lines 50 - 52)	895	$ 22,418		53

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XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Ken Bohannon	Asst. Administrator	100	$ 6,200
Lee Bohannon-Smith	Administrator	0	45,031
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 51,231

B. Administrative - Other

Description	Amount
	$
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	$

C. Professional Services

Vendor/Payee	Type	Amount
Stratton, Giganti, Stone & Kopec	Legal	$ 2,725
Thomas Benedick	Legal	150
American Express Bus. Services	Accounting	75
Boyce, Hund & Assoc.	Accounting	10,393
MPP&W, P.C.	Accounting	18,251
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed $2500 attach copy of invoices.)		$ 31,594

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 45,442
Unemployment Compensation Insurance	19,416
FICA Taxes	93,308
Employee Health Insurance	763
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Retirement Plan Expense	229
Employee Uniform Expense	191
Employee Gifts	49
Employee Memberships	35
Less: Employee Gifts	(49)
TOTAL (agree to Schedule V, line 22, col.8)	$ 159,384

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	2,169
Health Care Worker Background Check	112
(Indicate # of checks performed 8)	
INHAA Dues	200
MES/HPSI Member Fees	63
SSPI Member Fees	59
Promotional Advertising	5,511
	(5,511)
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 2,603

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	807
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 807

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number BOHANNON NURSING HOME # 0016964 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008	FY2009	FY2010
1			$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number BOHANNON NURSING HOME # 0016964 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **No**

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **INHAA - $200**

(3) Did the nursing home make political contributions or payments to a political action organization? **No** If YES, have these costs been properly adjusted out of the cost report? _____

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **No** If YES, what is the capacity? _____

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **N/A**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **185** Line **10**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease. _____

(9) Are you presently operating under a sublease agreement? _____ YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

_____

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ **50,653**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **No** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **Yes**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **No** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **0** Has any meal income been offset against related costs? **Yes** Indicate the amount. $ **1,128**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $ **N/A**
c. What percent of all travel expense relates to transportation of nurses and patients? **None**
d. Have vehicle usage logs been maintained? **N/A**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **No**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $ **N/A**

(17) Has an audit been performed by an independent certified public accounting firm? **No**
Firm Name: **N/A** The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? **N/A** If no, please explain. **N/A**

(18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? **Yes**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **Yes**
Attach invoices and a summary of services for all architect and appraisal fees.